

III. Wladimiroff-Mikulicz Osteoplastic Resection of the Foot. By W. B. HOPKINS, M. D. (Philadelphia). The author reports a case of this operation already referred to in the *ANNALS OF SURGERY*, vol. iii, p. 425, and vol. v, pp. 161 and 553, and making the twenty-second recorded case. A man, æt. 37, suffering from persistent traumatic ulcer of the heel was the subject of the operation. The author modified the operation: (1). By employing two sterilized bone dowels, one end of which was inserted into a hole in the lower extremity of the tibia and the other pressed downward into the tarsus, thus firmly fixing the tarsal bones to the tibia. (2). The divided and re-trenched ends of the peroneus longus, and the divided end of the tendo Achillis and the plantar fascia were severally brought together and sutured with catgut. A lighter suture united the ends of the re-trenched posterior tibial nerve. The former doubtless greatly promotes early union by providing perfect fixation, while the latter has without doubt added to the function of the foot. The result of the operation was perfectly satisfactory, the patient, after eight months, being able to walk four miles with cane and boot; has limited motion under voluntary control in flexion as well as extension, while the lengthening is only three quarters of an inch.—*Med. News*, Dec. 3, 1887.

JAMES E. PILCHER (U. S. Army).

IV. The Synovial Sacs and Tendon Sheaths of the Palm. By DR. A. VON ROSTHORN, (Vienna). This is essentially an anatomical study, though made with special reference to matters of practice. Previous works are reviewed, French descriptions meeting with most praise. The article is accompanied by colored plates, and a bibliography. Injections (principally of Teichmann's material), and anatomical preparation represent the methods employed. His aim was to establish, (a) the normal relations, and from these to formulate the general type, (b) whether there exists a free communication between the tendon sheaths of the thumb and little finger with the corresponding carpal sacs, (c), the kind of communication (d), the relation of superficial to deep flexors with regard to their enveloping synovial membranes, and also to their unclearly described so-called mesotendinea

(e), the numerous variations, their frequency and character, (f), standard illustrations.

The various details as to methods and particular cases must be read in the original.

The results he sums up under the following heads.

1. The mass of flexor tendons passing the wrist are united in a paquet by loose tissue, and further held together by a kind of smooth sheath of connective tissue.

2. Beneath the transverse carpal ligament are two synovial sacs separated by a sheath. These extend proximally and distally beyond the limits of the ligament.

3. They may suitably be termed radial and ulnar sacs. The former only has relations to the tendon of the flexor of the thumb, the latter only to the tendons of the fourth and fifth finger. The flexor tendons of the second and third fingers are outside of both sacs.

4. The so-called mesotendina or mesotena of the separate tendons are very regular in occurrence, position and form, but vary as to dimensions. They bear vessels for the tendons. The so-called pockets of the synovial sacs are but culs de sac, arising from taut mesotendinous membrane.

5. Originally, in the new-born, all 5 fingers possess separate phalangeal synovial sacs not in any way communicating with the carpal sacs. In early childhood those of the thumb and little fingers gradually extend to the carpal sheaths and finally—as is the rule in adults—communicate.

6. Communications in adults;

(a). The ulnar tip of the ulnar synovial sac (of palm) with the synovial sheath of the little finger, Exceptionally it ends blind.

(b). The radial synovial of the palm regularly with the synovial sheath of the thumb.

7. The middle three fingers possess each its completely closed phalangeal synovial sheath; though it is possible that occasionally the fourth may communicate with the tip of the ulnar sac.

8. The tendons of the common superficial flexors present a variable relation.

(a). Those of second and third fingers lie quite exterior to the carpal sacs. Only in isolated cases do they have an independent genuine synovial sheath, most frequently the index.

(b). The superficial flexors of the fourth and fifth fingers enter the ulnar carpal sac, and are supplied by its prolongation. Once he achieved a separate injection of the sheaths.

6. Instead of 2 carpal sacs, occasionally there are 3. Of these latter cases he makes two subdivision ;

(a). Most frequently the 2 carpal sacs are somewhat shortened, and the dividing septum separates toward the forearm to include the third wedge shaped sac.

(b). Less often both typical sacs are greatly reduced. Instead a large third sac extends far distally, through this runs the deep flexor of the index. These variations are usually found in the hands of elderly laborers. In women and youth he only found the usual number. Of 20 hands, 11 showed the normal type, 9 form *a*, and 3 form *b*.

10. The communication between radial and ulnar carpal sacs, recorded in one case by Gosselin, he has never observed, neither any between carpal synovial sacs and joints.—*Arch. f. kl. Chirg.* bd. 34. hft. iv, 1887.

WM. BROWNING (Brooklyn).

V. The Treatment of Felon Without Incision. By L. DUNCAN BULKLEY, M.D. (New York). Believing that subjects are commonly in a state of lowered vitality, often with a sluggish condition of the digestive organs, the author begins with a mild cathartic, and administers a tonic, preferably the following :

R	Magnesi sulphatis,	-	-	-	3i
	Ferri sulphatis,	-	-	-	3i
	Acidi sulphurici dil.,	-	-	-	3iv
	Syrupi zingiberis,	-	-	-	3i
	Aquæ q. s. ad,	-	-	-	3iv

M. Sig. Teaspoonful in water, through a tube, after eating

In addition to this a gelatine coated pill of one-fourth grain of sulphide of calcium is administered every two hours. Careful attention is given to the diet.